BEFORE THE ARKANSAS WORKERS' COMPENSATION COMMISSION

CLAIM NO. F108142

DONNA KEY, EMPLOYEE	**CLAIMANT**
OWENS CORNING CORPORATION, EMPLOYER	**RESPONDENT**
OLD REPUBLIC INSURANCE CO., CARRIER	**RESPONDENT**

OPINION FILED OCTOBER 14, 2005

Upon review before the FULL COMMISSION, Little Rock, Pulaski County, Arkansas.

Claimant represented by HONORABLE EDDIE WALKER, JR., Attorney at Law, Fort Smith, Arkansas.

Respondent represented by HONORABLE JEREMY SWEARINGEN, Attorney at Law, Little Rock, Arkansas.

Decision of Administrative Law Judge: Reversed.

OPINION AND ORDER

The respondents appeal and claimant cross-appeals a decision by the Administrative Law Judge filed January 12, 2005. The respondents specifically appeal that portion of the Administrative Law Judge’s opinion finding that the claimant is entitled to a whole body impairment rating of 7% for her finding of reflex sympathetic dystrophy (RSD) as assessed by Dr. Ackerman, over and above the 14% previously accepted and paid by the respondents. In addition, the respondents appeal a finding that the claimant is entitled

to wage loss in the amount of an additional 7% over and above the 7% impairment rating for her RSD. The claimant cross-appeals that portion of the Administrative Law Judge's opinion finding that the claimant has proven that she is entitled to only 7% wage loss disability as a result of her compensable injury.

Our carefully conducted de novo review of this claim in its entirety reveals that the claimant has failed to prove by a preponderance of the evidence that she is entitled to a whole body impairment rating of 7%. Likewise, the claimant has failed to prove by a preponderance of the evidence that she is entitled to wage loss in the amount of an additional 7% over and above the 7% whole body impairment rating awarded for her alleged condition.

It is undisputed that the claimant fell at work on July 10, 2001, injuring her right foot and ankle. Thereafter, the medical record reveals that the claimant came under the care of several physicians for the treatment of her compensable injury, beginning with Dr. Michael Wolfe. On July 26, 2001, Dr. Wolfe opined that the claimant had

sprained her ankle and he released her to light duty. The claimant's symptoms reportedly persisted, so she returned to Dr. Wolfe, who prescribed physical therapy. An MRI conducted on August 24, 2001, revealed "[p]ossible inflammatory type changes in the [claimant's] subcutaneous tissues both medial and laterally." A bone scan of the claimant's feet and ankles conducted on August 13, 2001, subsequently revealed mild arthritic changes, with "no evidence of [RSD] on the right." After this scan, the claimant initiated treatment with her family physician, Dr. Joe Paul Alberty, who examined the claimant and referred her Dr. John Swicegood. On November 2, 2001, a three-phase bone scan of the claimant's ankles and feet revealed findings consistent with reflex sympathetic dystrophy (RSD), which has been defined as a type of chronic pain syndrome. See generally, Wal Mart Stores, Inc. v. Connell, 340 Ark. 475, 10 S.W.3d 727 (2000). In response to this finding, Dr. Swicegood administered a series of right lumbar sympathetic nerve block injections, as well as a percutaneous sympathetic radiofrequency

neurotomy. These procedures reportedly failed to provide the claimant with lasting relief from her symptoms.

A second MRI of the claimant’s right foot and ankle conducted on December 21, 2001, showed moderate diffuse soft tissue edema around the right ankle, but no focal abnormality.

A functional capacity evaluation conducted on December 28, 2001, indicated that the claimant was capable of working a job that required no more than 30 minutes of prolonged standing and 30 minutes of prolonged sitting, with a minimal lifting at waist level. On January 16, 2002, Dr. Keith Holder released the claimant to limited work hours with certain restrictions. The claimant did not return to work, and she was referred to Dr. Ackerman for further evaluation and treatment. During her examination on March 17, 2002, Dr. Ackerman observed decreased flexion of the claimant’s right ankle, tenderness, temperature changes between her lower extremities, and discoloration of both feet. Although these symptoms are consistent with RSD, Dr. Ackerman did not observe any muscle wasting,

hypersensitivity to touch, or excessive sweating (hyperhidrosis), which are also common symptoms of RSD. Uncertain about the etiology of the claimant's symptoms, Dr. Ackerman ordered another EMG/NCE, with laser Doppler study. In the meantime, Dr. Ackerman diagnosed the claimant with neuritis and he opined that her condition had been caused by either a "tarsal tunnel syndrome and/or a ligamentous injury." In his October deposition, Dr. Ackerman agreed that the claimant's problems at the time of her March 17th examination were attributable to the tenosynovitis, which is why, he explained, he eventually referred the claimant to Dr. Steven Kulik for surgery.

The claimant's laser Doppler test indicated that the claimant's sympathetic nervous system was intact, and that she did not have RSD. Likewise, the claimant's nerve conduction study was negative, and it indicated no abnormalities in the claimant's lower extremities, and no evidence of radiculopathy or neuropathy. In subsequent examinations, the claimant continued to present to Dr. Ackerman with varying and inconsistent symptoms. For

example, on March 25, 2002, Dr. Ackerman found no difference in temperature between the claimant's lower extremities, whereas on April 23, 2002, the claimant's right foot appeared to be warmer than her left. On March 25th, Dr. Ackerman observed some edema, but he noted no hyperhidrosis. One month later, the claimant's right foot showed some redness, but it showed no allodynia and still no hyperhidrosis. In his deposition of October 5th, 2004, Dr. Ackerman stated that RSD is dynamic in nature and that symptoms of this condition can vary from examination to examination. Dr. Ackerman agreed, however, that variation of symptoms is also common with other neurological conditions, such as neuritis.

As previously mentioned, Dr. Ackerman eventually referred the claimant to Dr. Kulik. On May 16, 2002, Dr. Kulik noted some swelling, tenderness, and limited ankle motion in the claimant's lower right extremity. Dr. Kulik diagnosed the claimant with a right peroneal tear, for which he administered a peroneal injection. On May 22, 2002, Dr. Ackerman agreed with Dr. Kulik that the claimant's

symptoms were not caused by RSD. On July 19, 2002, Dr. Kulik performed a tenosynovectomy of the peroneal tendons of the claimant's lower right extremity, with a grove deepening removal of extostosis from the distal posterolateral fibula.

After her surgery, the claimant sought follow-up treatment with Dr. Robert Thompson, who ordered additional x-rays. These films revealed a visible normal bone structure bilaterally with no evidence of radiculopathy or punctate changes that might be expected with RSD. The claimant returned to Dr. Ackerman on October 9, 2002. During that examination, Dr. Ackerman noted no difference in temperature between the claimant's right and left legs. Although Dr. Ackerman did note some swelling in both of the claimant's feet, he found no hypersensitivity, excessive sweating, discoloration, or hair changes, which as previously mentioned, are consistent with RSD. However, Dr. Ackerman noted that the claimant demonstrated "global pain," which is consistent with RSD. Again, Dr. Ackerman diagnosed the claimant with neuritis, and he ordered another

three-phase bone scan, which according to the medical record was never done.

On December 11, 2002, Dr. Kulik opined that the claimant had reached maximum medical improvement and he released her to return to a sedentary job with standing, walking, climbing, and lifting restrictions. In addition, Dr. Kulik assigned the claimant with a 14% impairment rating to her lower extremity based upon her surgically repaired torn peroneal tendon. Thereafter, the respondents paid permanent disability benefits based upon this 14% rating.

The claimant returned to Dr. Ackerman on Febraury 11, 2003, at which time he noted symmetrical temperature, but some swelling, discoloration, and excessive sweating bilaterally. Dr. Ackerman suspected that the claimant’s neuritis had spread to her opposite extremity. He also noted that “RSD has been ruled out.” In a later examination, Dr. Ackerman reported that the claimant displayed some sensitivity to touch, but that there was no temperature difference between her extremities and no sweating. Dr. Ackerman recommended installation of a dorsal

column stimulator, which the claimant refused. In subsequent examinations, Dr. Ackerman noted an absence of symptoms consistent with RSD, and by his examination of the claimant on January 14, 2004, he stated that he was unsure as to the claimant's proper diagnosis: neuritis or RSD. On March 10, 2004, Dr. Ackerman opined that the claimant had reached the end of her healing period, and that she could return to sedentary type work. On May 24, 2004, Dr. Ackerman assigned the claimant with a 7% impairment rating to the claimant's body as a whole based upon her tenuous diagnosis of RSD.

The claimant underwent a functional capacity evaluation on October 4, 2004, which indicated that she gave an unreliable and inconsistent effort, as well having displayed symptom magnification. About a week later, on October 19, 2004, the claimant underwent a vocational assessment conducted by vocational consultant, Mr. Richard Marron. After a two hour meeting with the client, which included an in-depth interview and review of her medical records, Mr. Marron concluded that the claimant is able to perform sedentary type work. Mr. Marron further concluded

that the claimant’s receipt of social security and long-term disability benefits acted against her motivation to return to work. Although the claimant admitted that she could perform duties that allow her to alternate between sitting and standing, and that she has no functional disability involving her upper extremities, she has presently made no effort to return to work.

Injured workers bear the burden of proving by a preponderance of the evidence that they are entitled to an award for a permanent physical impairment. Moreover, it is the duty of this Commission to determine whether any permanent anatomical impairment resulted from the injury, and, if it is determined that such an impairment did occur, the Commission has a duty to determine the precise degree of anatomical loss of use. Johnson v. General Dynamics,46 Ark. App. 188, 878 S.W.2d 411 (1994); Crow v. Weyerhaeuser Co., 46 Ark. App. 295, 880 S.W.2d 320 (1994). Physical impairments occur when an anatomical or physiological abnormality permanently limits the ability of the worker to effectively use part of the body or the body as a whole.

Consequently, an injured worker must prove that the work-related injury resulted in a physical abnormality which limits the ability of the worker to effectively use part of the body or the body as a whole. In considering such claims, the Commission must first determine whether the evidence shows the presence of an abnormality which could reasonably be expected to produce the permanent physical impairment alleged by the injured worker. Crow, supra.

Any determination of the existence or extent of physical impairment shall be supported by objective and measurable physical or mental findings. Ark. Code Ann. §11-9-704(c)(1). Objective findings are statutorily defined as "those findings which cannot come under the voluntary control of the patient." Ark. Code Ann. § 11-9-102(16). The Commission cannot consider complaints of pain when determining physical or anatomical impairment. Id. The Commission has the authority and the duty to weigh medical evidence to determine its medical soundness, and we have the authority to accept or reject medical evidence. Mack v. Tyson Foods, Inc., 28 Ark. App. 299, 771 S.W.2d 794 (1989);

Wasson v. Losey, 11 Ark. App. 302, 669 S.W.2d 516 (1984); Farmers Insurance Co. v. Buchheit, 21 Ark. App. 7, 727 S.W.2d 391 (1987). Likewise, the Commission is entitled to examine the basis for a physician's opinion, like that of any other expert, in deciding the weight to which that opinion is entitled. However, as with any evidence, we can not arbitrarily disregard the testimony of any witness. In making determinations regarding the existence and extent of anatomical loss of use, we are not limited solely to medical evidence. Finally, in assessing permanent anatomical impairment, the Commission has adopted the AMA Guides to the Evaluation of Permanent Impairment (4th edition 1993) exclusive of any sections which refer to pain and exclusive of straight leg raising tests or range of motion tests when making physical or anatomical impairment ratings to the spine. See Commission Rule 34; see also, Ark. Code Ann. §11-9-5199h), 11-9-521(h), and 11-9-522(g).

The wage loss factor is the extent to which a compensable injury has affected the claimant's ability to earn a livelihood. Sapp v. Phelps Trucking, Inc., 64 Ark.

App. 221, 984 S.W.2d 817 (1998). To be entitled to any wage-loss disability benefit in excess of permanent physical impairment, a claimant must first prove, by a preponderance of the evidence, that he or she sustained permanent physical impairment as a result of a compensable injury. Smith v. Gerber Prods., 54 Ark. App. 57, 922 S.W.2d 365 (1996). Furthermore, Ark. Code Ann. §11-9-522(b)(1)clearly states that the percentage of permanent physical impairment must be established before the Worker's Compensation Commission can consider a claim for permanent partial disability benefits in excess of the employee's percentage of permanent physical impairment. Wal Mart Stores, Inc. v. Connell, 340 Ark. 475, 10 S.W.3d 882 (2000). Similarly, any consideration of the employee's age, education, work experience, and other matters reasonably expected to affect the his earning capacity may not occur until the commission has first determined the percentage of permanent physical impairment. Id. Permanent benefits shall be awarded only upon a determination that the compensable injury was the major

cause the disability or impairment. Ark. Code Ann. §11-9-102(4)(F)(ii)

In a fairly recent decision the Full Commission found that it was "without the means" to assign the claimant an impairment rating for her RSD under the AMA Guides (4th edition) based on objective physical findings, as the term objective findings has been defined in Ark. Code Ann. §11-9-102(16). Henderson v. Riverside Furniture, Full Commission opinion filed June 3, 2003 (F104235). In that decision, the Commission was faced with similar facts as the case at hand. For example, the parties stipulated to the compensability of the claimant's right leg injury. Further, the claimant subsequently developed RSD and the parties litigated the claimant's entitlement to permanent partial disability benefits, wage loss benefits, and degree of permanent physical impairment. In reaching its conclusion, the Commission stated the following:

> On the record before us, we are once again constrained to conclude, as the Full Commission concluded under the circumstances in Wal Mart Stores, Inc. V. Connell, 340 Ark. 475, 10 S.W.3d 727 (2000), that we have no evidence in the record before us with which to assign the claimant an impairment rating for

her RSD under the AMA Guides (4th edition) based on objective physical findings, as the term objective findings has been defined in Ark. Code Ann. §11-9-102(16). In reaching this decision, we note, as did the Administrative law Judge, that Dr. Gary Moffitt has calculated a 16% impairment to the claimant's lower extremity under the AMA Guides (4th edition) for her reflex sympathetic dystrophy based upon procedures identified on page 3/56 of the AMA Guides and based on Table 11(a) on page 3/48 of the AMA Guides. The text on page 3/56 and the text on page 3/48 accompanying Table 11(a)indicate that the calculation methods relied on by Dr. Moffitt determined an impairment rating which is not based on objective medical findings, but that is instead based on patient pain or sensory deficit. Moreover, the various ratings assigned are graded based on the subjective degree to which the pain or sensory deficit are perceived to interfere with the patient's activities of daily living. Therefore, the grading criteria can come within the voluntary control of the patient. Because Dr. Moffitt's method for determining the existence and extent, if any, of the claimant's physical impairment caused by RSD under Table 11(a) is not based on or supported by objective physical findings, we are constrained to conclude, as the Commission did in Wal mart Stores, Inc. v. Connell, supra, that we are without the means on this record to determine the existence and extent of the claimant's physical impairment, if any,

> from RSD consistent with the requirements of Ark. Code Ann. §11-9-704(c)(1)(B). Therefore, we find that the Administrative Law Judge's award for 6% permanent impairment rating to the body as whole must be reversed.

In the case before us, Dr. Ackerman admitted during his deposition of October 5, 2004, that he used the criteria set forth in Chapter 3, Page 56 of the AMA Guides (4th edition) to assess the claimant with a 7% impairment rating. Furthermore, in the letter dated May 24, 2004, in which Dr. Ackerman assigned the claimant this impairment rating, he stated:

> In the AMA guidelines, 4th edition, it does not give a separate table for reflex sympathetic dystrophy [and] leaves the impairment rating to the physician.

In addition to admitted, as stated above, that he did not follow AMA guidelines in assigning the claimant's impairment rating, Dr. Ackerman further admitted that RSD is a "pathological entity that causes a person to have pain that is really out of proportion to one's injury." According to the Commission in Thomason v. R & W Trucking Co., Full

Commission Opinion filed July 13, 2000 (E419287), AMA Guides permits the consideration of sensory deficit, pain, and motor deficit, which are all subjective factors which come under the voluntary control of the claimant. In addition, the Commission noted in Thomason that since the Arkansas Worker's Compensation Act precludes the consideration of subjective factors when assigning an impairment rating, "[t]here is no permissible way to rate a specific percentage of impairment for [RSD] under the Guides... ." Moreover, as indicated above, in accordance with Wal Mart Stores, Inc. v. Connell, supra, the Commission has previously found, therefore, that there are no criteria under the AMA Guides for validly assigning a permanent impairment rating. Henderson, supra; see also, Gentry v. Poulan Weedeater, Full Commission Opinion filed June 3, 2003 (F104235), Potocki v. St. Edward Mercy Medical Center, Full Commission Opinion filed February 3, 2004 (F004149). Finally, the respondents are correct in their assertion that "the 'dynamic' nature of a condition such as RSD defies any objective assessment of permanent impairment." This assertion is supported by

Dr. Ackerman's October testimony concerning the nature of RSD.

> And again, being a dynamic entity, you're going to see a person examining the patient or the patient themselves are going to see changes. Some days the swelling may go away. Some days the allodynia or the pain to touch will be there. So, it's such a dynamic entity that at one time, at least one visit, that there has to be certain criteria met for the diagnosis of reflex sympathetic dystrophy. Now, Dr. Swicegood had seen that.

Dr. Ackerman further explained that, due to its dynamic nature, RSD is quite difficult to diagnose, as was illustrated by the claimant's case.

> I didn't see all the criteria, because the criteria I'm seeing, they're suggestive but not definitive of the reflex sympathetic dystrophy. So, in other words, some days I see it and looks like there was definitely [RSD] there, where other days it looks like there's definite pathology going on, pain, touch, and so forth, but not the [RSD].

Dr. Ackerman named several other conditions which manifest in symptoms consistent with RSD. For example, a

patient with neuritis will display many of the same symptoms as seen with RSD. Dr. Ackerman also agreed that the claimant’s extreme obesity could be the source of some of her symptoms. Furthermore, Dr. Ackerman agreed that the permanency of the claimant’s condition is questionable, in that several of her symptoms, such as edema and hyperhidrosis, may disappear for a period of time or forever. Dr. Ackerman added that surgery or the implantation of a dorsal column stimulator could also help reduce the claimant’s level of impairment.

Based upon the above and foregoing, the claimant has failed to prove by a preponderance of the evidence that she is entitled to an award of permanent physical impairment of 7% to the body as a whole for RSD. Because the claimant has failed to prove that she is entitled to permanent physical impairment rating for her RSD, she has also failed to prove that she is entitled to wage loss benefits as awarded by the Administrative Law Judge. Furthermore, because we find that the claimant has failed to prove entitlement to a permanent impairment rating due to RSD, and

consequently to wage loss benefits, we do not address the issue raised by the1 claimant on cross-appeal. Therefore, the decision of the Administrative Law Judge should be reversed and this claim denied.

IT IS SO ORDERED.

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OLAN W. REEVES, Chairman

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KAREN H. McKINNEY, Commissioner

Commissioner Turner dissents.